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**ZAMBIA**

# COMMUNICATIONS SUPPORT FOR HEALTH

## BASELINE EVALUATION REPORT

**Contract No: GHS-I-007-00004-00; Order No. GHS-I-05-07-00004**

**March 2011**

This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International Inc..

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government

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# ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
BCC	Behavior Change Communication
CP	Cooperating Partners
CSH	Communications Support for Health
DACA	District AIDS Coordination Advisors
DHS	Demographic and Health Survey
FP/RH	Family Planning/Reproductive Health
GRZ	Government of the Republic of Zambia
HCRC	Health Communication Resource Centre
HIV	Human Immunodeficiency Virus
HPU	Health Promotion Unit
HMIS	Health Management Information System
ICT	Information Communication Technology
IEC	Information, Education, and Communication
IR	Intermediate Results
IRS	Indoor Residual Spraying
IT	Information Technology
ITN	Insecticide-Treated Net
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MIS	Malaria Indicator Survey
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
NAC	National AIDS/TB/STI Council
NGO	Non-Governmental Organization
NHSP	National Health Strategic Plan 2006–2010
NMCC	National Malaria Control Centre
PACA	Provincial AIDS Coordination Advisors
PHP	Public Health Program
PMEP	Performance Management and Evaluation Plan

PMTCT	Prevention of Mother-to-Child Transmission
SBS	Sexual Behavior Survey
STI	Sexually Transmitted Infections
TWG	Technical Working Groups
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Testing and Counseling
ZDHS	Zambia Demographic and Health Survey

# 1. INTRODUCTION

The Government of the Republic of Zambia (GRZ), through the Ministry of Health (MOH), has committed to achieving Millennium Development Goals (MDG) targets by improving the quality of health care services and providing greater and equitable access to health care for its people. To support these objectives, USAID is providing technical assistance to the GRZ in strengthening national health communications activities. The aim is for GRZ health communications activities, supported by the Communications Support for Health Program Project (CSH), to translate into increased, sustainable local capacity and positive behavior change that reinforce GRZ efforts in four focal areas: HIV/AIDS; malaria; family planning/reproductive health (FP/RH); and maternal, newborn, and child health (MNCH), including nutrition, which is an integral part of MNCH.

CSH operates primarily at the national level, providing technical assistance to the GRZ in the development, implementation, and evaluation of health communications activities. This will be done consistently with a focus on capacity building and transfer of skills. In the context of CSH, “GRZ” refers to three primary agencies—the Ministry of Health (MOH), the National Malaria Control Centre (NMCC), and the National HIV/AIDS/STI/TB Council (NAC). The CSH project will also work with and support other USAID partner programs in behavior change communications (BCC) to improve message effectiveness, consistency, and efficiency. CSH will provide direct support to GRZ in the planning, design, implementation, and monitoring and evaluation of communications campaigns and activities.

## 1.1 CSH Results Framework

The CSH Results Framework (Annex A) outlines the results the project will need, to achieve the project objective: local ability to implement effective information, education, and communication (IEC)/BCC activities. “Effective” means that IEC and BCC activities implemented by the GRZ result in a measureable reduction in the practice of risky behaviors and/or an increase in demand for and use of health care services by the general population. The project objective is aligned with USAID’s strategic objective for health and activities will contribute to achieving mission results. The project will work toward four intermediate results (IR), with each IR aligned to a defined contract task.

- *Intermediate Result 1 (IR 1):* National health communications campaigns strengthened.
- *Intermediate Result 2 (IR 2):* GRZ use of evidence-based health communications approaches increased.
- *Intermediate Result 3 (IR3):* Local capacity to support sustained implementation of IEC/BCC activities strengthened.
- *Intermediate Result 4 (IR 4):* Coordination of IEC/BCC activities between USAID projects increased.

Each IR (and task) represents a different approach to building local capacity. Although the IRs (or tasks) are presented separately, there are many linkages and interrelationships among them.

## **1.2 Baseline Evaluation: Purpose and Structure of Report**

The purpose of this report is to provide baseline information regarding the different components of the Results Framework and, more specifically, to the indicators included in the Performance Monitoring and Evaluation Plan (PMEP). Furthermore, it provides baseline levels for the project's indicators that will help establish appropriate and realistic benchmarks for CSH. The information provided also serves to inform the planning and implementation of the project.

The findings presented in this baseline report are presented following the order of the PMEP. Two more evaluation reports with this same structure (for direct comparison) will be produced for the midline (2012) and endline (2014) evaluation results. This will allow for a future trend analysis of the indicators, as well as examining changes over time in the more descriptive sections.

## **2. METHODOLOGY**

The baseline evaluation was carried out from July 2010 through November 2010, by the CSH project team in Zambia. The evaluation incorporated both primary and secondary data collection.

### **2.1 Primary Data Collection**

#### **2.1.1 Key Informant Interviews**

Key informant interviews were the main form of primary data collection. Eleven key informant interviews were conducted with key staff members of GRZ from the MOH, NAC, and NMCC involved in the planning and/or implementing IEC/BCC campaigns, including monitoring and evaluation. Interviews were semi-structured and included a combination of open-ended and closed questions. Questions solicited information regarding perceptions of capacity of staff for implementing IEC/BCC activities (for all stages of IEC/BCC development) and information regarding current national communication campaign approaches, materials, and messages.

Interviews were also conducted with senior technical and management staff at CHAMP. Questions solicited information regarding perceptions of organizational and management capacity of the Talkline call center, information on current operating procedures, and potential areas where CSH could provide support.

Lastly, interviews were conducted with the MOH librarian and a BCC specialist from the NAC to solicit information regarding the current activities implemented by Health Communication Resource Centers (HCRCs); the current capacity of HCRCs to collect, manage, and share IEC/BCC materials; and ideas of potential areas for expanding the existing HCRC into learning centers.

#### **2.1.2 Focus Group Discussions**

A total of three focus group discussions were conducted. One focus group discussion was held with five staff members from the local non-governmental organization (NGO) Afya Mzuri, one with four staff members from the Health Promotion Unit of the MOH, and one with five staff members from the CHAMP Talkline. The focus groups were conducted to gain information about the current activities implemented by the HCRC; the current capacity of HCRC to collect, manage, and share IEC/BCC materials; and ideas of potential areas for expanding into learning centers. The intent of the focus group discussion with CHAMP staff members was to assess the capacity of the Talkline to manage and disseminate health information.

#### **2.1.3 Observations**

Observations were conducted of the counselors working at the Talkline call center at CHAMP. Observations were supplemented with discussions with key staff to assess the current operating procedures for the Talkline call center. Observations were also conducted at the MOH and NAC HCRCs to assess all the key functions of the HCRCs.

## **2.2 Secondary Data Collection**

The evaluation included a review of several policy and program-related documents and reports from the three GRZ institutions (MOH, NAC, and NMCC), Afya Mzuri Dziwani, and CHAMP. The key documents included; strategic plans, monitoring and evaluation plans, communication strategies and IEC/BCC reports. Information from these documents was synthesized and triangulated with the data collected from the surveys, interviews, and focus group discussions.

Additionally, national population health surveys were reviewed for baseline on behavior and health outcomes for the four focal areas: HIV, malaria, FP/RH, and MNCH. The surveys reviewed included the Zambia 2007 Demographic and Health Survey (DHS), the Zambia 2010 Malaria Indicator Survey (MIS), and the Zambia 2009 Sexual Behavior Survey (SBS).

## **2.3 Additional Data Collection**

There is specific baseline information that remains to be collected and included in this report – see Annex B for more details. This baseline evaluation report will be updated when the additional information becomes available (most in April, 2011).

## **2.4 Limitations of Methodology**

The findings on GRZ capacity for IEC/BCC planning and implementation were limited to the staff members from MOH, NAC, and NMCC who were available for an interview during the evaluation period. Due to the short timeframe of the evaluation, interviews could not be conducted with all key members identified as being involved in the planning and implementation of IEC/BCC activities.

Furthermore, interviews with other GRZ institutions, USAID implementing partners, the private sector, or other local NGOs involved in IEC/BCC activities were not included in the evaluation. The incorporation of outside sources beyond the MOH, NAC, and NMCC may have provided more insight into identifying how the capacity of these institutions could be strengthened.

Lastly, data for the behavior and health indicators were limited to the national health surveys available. For many of the indicators, the most recent data available were from the 2007 DHS; thus the baseline indicators may not reflect changes that have occurred from 2007 to 2010.

### 3. BASELINE FINDINGS

The findings from the baseline evaluation are presented by each of the major components of the PMEP. The first section summarizes the key findings related to the behavior outcomes and health impact indicators for GRZ's four main focal areas: HIV, malaria, FP/RH and MNCH. This is followed by the key findings related to the main project objective, strengthening the capacity of GRZ to manage effective IEC/BCC activities, and for each of the four IR areas.

#### 3.1 Behavior Outcomes and Health Impact Indicators for HIV, Malaria, FP/RH, and MNCH

The behavior and health indicators are grouped by their specific focal area: HIV, malaria, FP/RH, and MNCH. Each group includes a set of indicators that will be analyzed at baseline, midline, and endline.

It is important to note, that at the end of the CSH project in 2014, the data for the indicators (HIV, FP/RH and MNCH in particular) that are measured by the DHS will not be available, since the DHS will only take place in 2012 (data will be used for the midline) and 2017. The possibility of using an alternative source of data in 2014 will be explored, to provide the endline levels of the relevant indicators. In relation to Malaria indicators, since the MIS has been conducted in Zambia every two years since 2006, (the baseline data is from the 2010 survey), it is expected that the midline data will come from the 2012 survey and the endline data, from the one conducted in 2014.

##### 3.1.1 Overview of Zambia's Health Situation at the Time of the Baseline

Between 2002 and 2007, the overall health situation, with some exceptions, improved in Zambia. Table 3.1, while not exhaustive in the information presented, summarizes trends in key indicators pertaining to USAID/Zambia's health portfolio.

**Table 3.1 Trends in Key Health Indicators for Zambia**

Category	Indicator	DHS 2002	DHS 2007
	HIV prevalence among adults age 15 – 49		
	Females	17.8%	16.1%
	Males	12.9%	12.3%
	Urban	23.1%	19.7%
	Rural	10.8%	10.3%
	HIV prevalence among pregnant women age 15 - 39	19%	16.6%
Malaria	New malaria cases per 1,000 people	377	358
	Prevalence of malaria parasites among children under 5	22.1%*	16%**

FP/RH	Total fertility rate	5.9	6.2
	Urban	4.3	4.3
	Rural	6.9	7.5
	Use of any modern contraceptive method among currently married women age 15 - 49	22.6%	32.7%
MNCH	Maternal mortality per 100,000 live births	729	591
	Under-five mortality per 1,000 live births	168	119
	Neonatal mortality per 1,000 live births	37	34
	Infant mortality per 1,000 live births	70	95
	Child mortality per 1,000 live births	81	52
	Prevalence of stunting in children under five	46.8%	45%
	Severely stunted	22.2%	21%

\* 2006 Zambia Malaria Indicator Survey

\*\*2010 Zambia Malaria Indicator Survey

### 3.1.2 CSH HIV Indicators

The specific HIV indicators included in the PMEP of CSH and their baseline levels are provided in Table 3.2

**Table 3.2 CSH HIV Indicators**

HIV Indicators*	Baseline DHS 2007
1. Percentage of young women and men aged 15–19 who have had sexual intercourse before the age of 15	M: 6% F: 7%
2. % of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	M: 49.9% F: 37.4%
3. % of females and males aged 15–49 who had two or more concurrent partnerships in the last 12 months (by residence)	M: 70% F: 30%
4. % of women and men aged 15-49 who received an HIV test in the last 12 months	M: 11.7% F: 8.5%

\*These indicators are in line with the 2011 – 2015 National HIV/AIDS/TB/STI M&E Framework, NAC

### 3.1.3 CSH Malaria Indicators

The specific Malaria indicators included in the PMEP and their baseline levels are provided in Table 3.3.

**Table 3.3 CSH Malaria Indicators**

<b>Malaria Indicators</b>	<b>Baseline MIS 2010</b>
1. % of households that received indoor residual spraying (IRS)	23.1%
2. % of children under age 5 and pregnant women who slept under an ITN last night	Cu5: 49.9% Pw: 45.9%
3. % of pregnant women who received complete IPTP during their pregnancy	69.4%
4. % of febrile children under 5 who received prompt and appropriate treatment	31.2%

*Data source for Table 4.2: Malaria Indicator Survey, 2010*

### 3.1.4 Family Planning/Reproductive Health

The specific FP/RH indicators included in the PMEP and their baseline levels are provided in Table 3.4.

**Table 3.4 CSH FP/RH Indicators**

<b>FP/RH Indicators</b>	<b>Baseline DHS 2007</b>
1. % of births that occur less than three years after the preceding birth	54.9%
2. Median age at first birth	19
3. % of women age 15–19 who have already had their first child	21.7%
4. % of women age 15–19 who will give birth to their first child	6.2%
5. % of married women age 15–49 currently using a modern contraceptive method	32.7%
6. Unmet need for spacing or limiting births	Unmarried women: 18.0% (11.8% spacing, 6.2% limiting) Married women: 26.5% (17.1% spacing, 9.4% limiting)

### 3.1.5 Maternal, Neonatal and Child Health

The specific MNCH indicators included in the PMEP and their baseline levels are provided in Table 3.5.

**Table 3.5 CSH MNCH Indicators**

MNCH Indicators	Baseline	
	DHS 2007	HMIS 2010
1. % of deliveries in health facilities	47.7%	
2. Annual percentage of deliveries in health facilities supervised by a skilled health worker		TBD*
3. % of mothers who received their first post-natal check-up between 4 to 23 hours of their delivery	9.8%	
4. % of mothers who exclusively breastfeed in the first six months	60.9%	
5. Annual percentage of fully immunized children under the age of one year		TBD*
6. % of children who received their complete set of immunizations	55.0%	
7. Health center utilization by children below five years old		TBD*

\*To be determined (TBD)—see Annex B for more details.

### 3.2 Project Objective: Capacity of GRZ to Manage Effective IEC/BCC Activities Strengthened

The Project Objective states that, as a result of CSH activities, the capacity of the GRZ to manage effective IEC/BCC activities will be strengthened. Based on the wording of the specific indicators, the capacity of the GRZ will be defined as “strengthened” if the following three criteria are fulfilled:

1. GRZ IEC/BCC management capacity is increased.
2. Campaigns are developed according to IEC/BCC guidelines of the GRZ.
3. Campaigns are monitored and evaluated.

CSH has designated a set of indicators to monitor those activities over the life of the project (see Table 3.6).

**Table 3.6 CSH Project Objective Indicators and Annual Results**

Project Objective Indicators	Baseline
	2010
1. GRZ score on IEC/BCC management capacity index	TBD*
2. % of national IEC/BCC campaigns that are developed according to minimum GRZ standards/guidelines	TBD*
3. % of national IEC/BCC campaigns led by GRZ that were developed based on formative research	TBD*
4. % of national IEC/BCC campaigns that are monitored and evaluated	TBD*

\*To be determined (TBD)—see Annex B for more details.

### **3.2.1 GRZ IEC/BCC Management Capacity**

#### **3.2.1.1 MOH**

The responsibility of developing and disseminating IEC/BCC interventions at the MOH rests in the Directorate of Public Health and Research under its Health Promotion Unit (HPU). The HPU at MOH Headquarters has IEC/BCC officers assigned to each of the eight public health program (PHP) areas. These officials are in charge of developing, managing, implementing, and evaluating IEC/BCC activities for their respective PHP. Each province in the country has one Health Promotion Specialist. At the district level, there is no Health Promotion Specialist but a Focal Point Person responsible for IEC/BCC activities.

The HPU mandate is to coordinate effective and efficient education and promotion programs aimed at empowering individuals, families, and communities to develop healthy life styles. The HPU provides strategic direction for health promotion strategies, coordinates IEC/BCC activities among stakeholders in the country, and provides specialist health promotion assistance to the Technical Working Groups (TWGs) within the MOH

HPU activities are largely donor funded, thus reproduction of IEC/BCC materials on a large scale is done through partners. Since the MOH has inadequate materials storage facilities most IEC/BCC materials produced are stored by partners. The supply chain (that is, requests, supplies, and comments on IEC/BCC materials) is not systematically tracked to inform future relevant programs, and this absence of tracking limits effective distribution of materials, especially to rural areas, as partners may have priorities that are different from MOH.

Planning for IEC/BCC interventions within the ministry is conducted jointly with stakeholders. MOH is unable to conduct the research and planning necessary to develop evidence-based BCC messages and materials. Formative research is rarely conducted by the HPU due to the fact that the funding for such activities is not available. As a result, secondary data are used to inform the planning for IEC/BCC interventions. IEC/BCC monitoring indicators are identified and monitoring tools developed during strategic planning, which is

done in collaboration with cooperating partners (CPs). However these tools are not used consistently, and in most cases are not used at all.

### **3.2.1.2 National AIDS/STI/TB Council (NAC)**

The NAC has a clear organizational structure with separate IEC and BCC units, with clearly defined roles and responsibilities. The specialists within the unit have well-documented job descriptions. However, the IEC unit and BCC unit fall under different directorates within the NAC.

The funding that is received from donors cannot adequately support the implementation of IEC/BCC activities in the annual work plans. As a result of the constrained funding and inadequate human resources, the NAC is unable to conduct vital activities such as pretesting of materials.

The NAC has strong partnerships with civil society and the private sector. It works through all the line ministries and statutory bodies of the public sector. Strategic partnerships play a very important role in IEC/BCC intervention; for instance, collaborating partners develop and distribute IEC/BCC materials, while NAC provides strategic leadership. The NAC has structures at both provincial and district levels—Provincial AIDS Coordination Advisors (PACA) and District AIDS Coordination Advisors (DACA)—to coordinate IEC/BCC interventions. Both the PACA and the DACA need to improve their capacities in IEC/BCC in order to be able to effectively coordinate interventions. However, there is no documented training policy for BCC training in the country.

The NAC has developed guidelines for material development, adaptation, and reproduction, which are aimed at assisting organizations and individuals to develop materials in a more standardized and systematic manner. The resource center at the NAC serves as a hub of all strategic communication and is open to the public; however, the resource center is not fully used by the public and partners. It is also important to note that the NAC does not produce materials except for special national events, such as Voluntary Testing and Counseling (VCT) Day and World AIDS Day.

The NAC has developed a clear national monitoring and evaluation (M&E) system; however, this does not clearly address IEC/BCC interventions. The NAC embraces the “Three Ones” key principles, with one National AIDS Coordinating authority, one agreed upon national HIV/AIDS strategic plan and an agreed country level M&E plan that helps monitor and evaluate the impact of the HIV/AIDS interventions. While the NAC has incorporated a number of BCC indicators at the impact and outcome levels into the M&E plan, there are only two IEC indicators at output level.

### **3.2.1.3 National Malaria Control Centre (NMCC)**

The NMCC is part of the MOH and is supervised by the Directorate of Public Health and Research. The NMCC IEC/BCC interventions are coordinated by the Deputy Director of Public Health in charge of malaria and implemented by the IEC/BCC principal officer and the IEC/BCC TWG.

At the provincial level, the IEC/BCC is coordinated through the Senior Health Education Officer, while at the district level, it is coordinated through the malaria focal person or the environmental technician dealing with prevention of communicable diseases. These provincial and district officials are not trained in BCC and are mainly working only on IRS activities.

The NMCC collaborates with NGOs, community-based organizations, and private sector business partners from whom the NMCC receives financial support for specific IEC/BCC materials for campaigns and events, such as the World Malaria Day. The NMCC does not have a library or resource center for IEC/BCC materials, research studies, evaluations, reports, and other literature. The NMCC used to have a document storeroom, which has since been converted into an office for the principal IEC officer.

The dissemination of malaria information tends to be event driven rather than routine due to resource constraints. Hence most messages are delivered during events such as World Malaria Day and Southern African Development Community Malaria Week, rather than on a consistent basis. The lack of continuity results in inconsistencies in knowledge, beliefs and attitudes regarding malaria from the people and ultimately leads to less impact on behavior change.

Monitoring is not systematically carried out during some events, such as the National Child Malaria Week, and during staff visits to the partner sites. The NMCC receive some M&E information through the malaria indicator survey on IRS use and acceptability, and ITN use. However, there is not a list of comprehensive variables in these surveys that are specific to IEC/BCC. Some additional information on malaria is obtained through outreach activities by community health workers and neighborhood health committees. ....

### **3.2.2 Use of IEC/BCC Guidelines**

The MOH has IEC/BCC guidelines, which outline principles to be followed in the development of messages; however these guidelines have not been updated from the time they were developed. Key principles included in the guidelines are use of evidence, integration of messages, community engagement, multi-level approaches, use of multiple channels, and coordination among all partners. According to the MOH, although the communication strategies and guidelines are in place, their implementation and use are influenced and constrained by limited financial and human resources.

The NAC developed guidelines for material development, adaptation, and reproduction to assist organizations and individuals in developing materials in a more standardized and systematic manner, however their use by implementing partners is limited.

The NMCC has written guidelines and procedures for carrying out various malaria-related IEC/BCC tasks. These guidelines and procedures, in addition to clear and simple objectives and information on how to attain them are included in the Malaria Communication Strategy. The strategy was part of the initial training on IEC/BCC that was given to district health officers, such as health promotion officers, environmental officers, and malaria focal persons. A major gap still exists in the contextualization of these materials for lower-level communities. Implementing partners simply adapt (however, in many cases they do not)

materials developed at the national level for their local audience. Frequently, implementers do not follow the communication guidelines.

### **3.2.3 How Campaigns Are Monitored and Evaluated**

At the MOH, the HPU does not have an established system for M&E of national IEC/BCC campaign activities. Even where monitoring indicators and tools were identified and developed for IEC/BCC, M&E of individual campaign activities is rarely done, often due to shortage of both manpower and financial resources.

At NMCC, M&E is tagged to campaigns, such as the National Child Health Week, that have a malaria component and during staff visits to the partner sites. Most of the IEC/BCC indicators count the number of materials developed and distributed and not the outcome of the IEC materials in terms of reach, usefulness, and impact.

NAC conducts periodic reviews of communication approaches and materials to ensure that they are up to date and relevant to the context and realities. In collaboration with its partners, NAC carries out periodic research to measure the social or behavioral outcomes of HIV/AIDS interventions. Examples of these are the SBS, multiple and concurrent sexual partnership studies, and the prisons survey.

## **3.3 Intermediate Result 1 (IR 1): National Health Communication Campaigns Strengthened**

IR 1 states that, as a result of CSH activities, Zambian national health communication campaigns will be strengthened. Based on the wording of the sub-IRs for IR 1, national communication campaigns will be defined as “strengthened” if the following three criteria are fulfilled:

1. MNCH, malaria, and nutrition campaigns are integrated.
2. HIV/AIDS campaigns are comprehensive.
3. Campaigns are multi-channel and evidence-based.

**Table 3.7 CSH Intermediate Result 1 Indicators and Annual Results**

IR 1 Indicators	Baseline 2010
<b>Sub IR 1.1 Integrated malaria, MNCH, and nutrition campaigns expanded</b>	
1.1.1 # of IEC/BCC campaigns conducted in Zambia with CSH support that integrate malaria, MNCH, and nutrition	0
<b>Sub IR 1.2 Comprehensive HIV prevention campaigns expanded</b>	
1.2.1 # of IEC/BCC campaigns conducted in Zambia with CSH support that are comprehensive HIV campaigns	0
1.2.2 # of the targeted population reached with individual and/or small-group level (HIV) preventive interventions (supported by CSH) that are based on evidence and/or meet the minimum standards required	A&AB: 0 OP: 0
1.2.3 % of targeted population reached by channel (radio or TV), with CSH support	Radio: 0 TV: 0
<b>Sub IR 1.3 Evidence-based multi-channel health communication campaigns increased</b>	
1.3.1 Annual number of BCC campaigns conducted in Zambia with CSH support that used 2 or more channels	0
1.3.2 Annual number of BCC campaigns conducted in Zambia with CSH support in which evidence from research was used to develop health communication campaigns	0

### 3.3.1 Integration of MNCH, Malaria, and Nutrition

CSH has defined **integrated** as the combining of messages from different health issues (specifically maternal, newborn, child health, malaria, and nutrition) into one campaign. Between September 2009 and August 2010, the Zambian MOH conducted one MNCH campaign, four malaria campaigns, and two nutrition campaigns. None of the campaigns were integrated, as shown in Table 3.8.

**Table 3.8 Integration of MNCH, Malaria, and Nutrition**

	% of Campaigns Integrated: MNCH and Malaria*	% of Campaigns Integrated: MNCH and Nutrition**	% of Campaigns Integrated: Malaria and Nutrition***	% of Campaigns Integrated: MNCH, Malaria, and Nutrition****
<b>Baseline (September 2009– August 2010)</b>	0	0	0	0

\* Denominator is all MNCH and malaria campaigns.

\*\*Denominator is all MNCH and nutrition campaigns.

\*\*\*Denominator is all malaria and nutrition campaigns.

\*\*\*\*Denominator is all campaigns – MNCH, malaria and nutrition

### 3.3.2 Comprehensive HIV/AIDS Campaigns

Comprehensive HIV/AIDS Campaigns are campaigns that include messages related to more than one HIV topic, including different modes of prevention. For example, CSH is designing a comprehensive HIV/AIDS campaign that will focus on reducing multiple concurrent partnerships, PMTCT and condom use. Between September 2009 and August 2010, the Zambian National AIDS Council conducted six national HIV campaigns, 2 of which were comprehensive – One Love Kwasila and Male Circumcision.

### 3.3.3 Multi-Channel and Evidence-Based Campaigns

Between September 2009 and August 2010, the MOH conducted 14 campaigns: 64% were multi-channel (used two or more channels), but none were evidence based (Table 3.9).

**Table 3.9 Multi-Channel and Evidence-Based Campaigns**

	% of Campaigns That Were Multi-Channel	% of Multi-Channel Campaigns That Used Two Channels	% of Multi-Channel Campaigns That Used Three Channels	% of Multi-Channel Campaigns That Used Four Channels	% of Campaigns That Were Evidence-Based
<b>Baseline (September 2009– August 2010)</b>	64	7	7	50	0

### 3.4 Intermediate Result 2 (IR 2): GRZ Use of Evidence-Based Health Communications Approaches Increased

GRZ use of evidence-based communication approaches will be defined as “increased” if the following two criteria are fulfilled:

1. GRZ capacity to conduct formative research to develop national campaigns improved.
2. GRZ capacity to use evidence from existing research to develop health communications campaigns improved.

**Table 3.10 CSH Intermediate Result 2 Indicators and Annual Results**

IR 2 Indicators	Baseline 2010
<b>Sub IR 2.1: Capacity of HCRC to manage and disseminate information on IEC/BCC interventions increased*</b>	
<b>Sub IR 2.2: GRZ capacity to conduct formative research to develop national health communication campaigns improved</b>	
2.2.1 # of GRZ staff trained with CSH support in conducting formative research to inform the development of IEC/BCC campaigns	0
2.2.2 # of IEC/BCC campaigns supported by CSH in which formative research activities were supported by CSH	0
<b>Sub IR 2.3 GRZ capacity to use evidence from existing research to develop health communications campaigns improved**</b>	

\*Indicators for sub IR 2.1 are included under sub IR 3.1

\*\*Indicators for sub IR 2.3 will be measured by the indicators under 2.2 (2.2.1 and 2.2.2) since use of existing research is part of formative research

#### **3.4.1 GRZ Capacity to Use Formative Research and Evidence from Existing Research**

MOH communication interventions and activities are developed through a series of discussions and meetings with stakeholders, bilateral donor agencies, and implementers (MOH, 2009). The MOH does not carry out formative research but instead holds consultative meetings with partners and key stakeholders to carry out problem analysis before implementing BCC activities. Formative research conducted by partners for each specific program, and results are discussed with TWGs. These results feed into the planning process at MOH, including the design and development of national messages and materials.

At the NMCC, messages and materials are developed based on the lessons learned from previous campaigns. NMCC conducts formative research only if funding is available. Message development is coordinated by the national IEC/BCC TWG whose mandate is to

coordinate and provide technical expertise in the development of IEC/BCC materials and campaigns.

The NAC's role is to coordinate the design and production of HIV/AIDS and other related campaign materials. According to NAC, materials are stored at the resource center and the partners merely request them for reproduction. However, in cases where new materials and campaign messages have to be designed, the NAC provides leadership through technical support and guidance on the wording and design of the campaign materials.

Health promotion staff in the MOH, NMCC and NAC has not been trained in formative research or use of evidence to inform the design of health communication campaigns and interventions. The HPU in the MOH has no separate budget to undertake formative research. Even when research is conducted, accessing actual reports for review is very difficult, as most of these reports are not stored centrally at the HPU.

### **3.5 Intermediate Result 3 (IR 3): Local Capacity to Support Sustained Implementation of IEC/BCC Activities Strengthened**

IR 3 states that, as a result of CSH, local capacity to support sustained implementation of IEC/BCC activities will be strengthened. The local capacity will be defined as “strengthened” if the following three criteria are fulfilled:

1. Local capacity to support sustained implementation of IEC/BCC activities is strengthened by: national campaigns approved by the TWG; GRZ staff trained in IEC/BCC approaches; IEC/BCC tools developed and reviewed; capacity of Afya Mzuri HCRC to manage information increased, and CHAMP HIV Talkline staff trained and service expanded.
2. There is private sector participation in IEC/BCC programming and capacity building activities.
3. Capacity building program of local institutions strengthened (that use IEC/BCC curricula and pre-service curricula developed and/or revised).
4. M&E Framework of national health strategy (2011–2015) defines core indicators for IEC/BCC monitoring, and GRZ IEC/BCC campaign tracking system produces periodic reports.

**Table 3.11 CSH Intermediate Result 3 Indicators and Annual Results**

IR 3 Indicators	Baseline 2010
<b>Sub IR 3.1 Local capacity to support sustained implementation of IEC/BCC activities strengthened</b>	
3.1.1 % of national IEC/BCC campaigns that have been approved by the IEC/BCC TWG, as a result of CSH support	0
3.1.2 # of GRZ staff trained with CSH support in IEC/BCC approaches	0
3.1.3 National IEC/BCC associated tools developed and annually reviewed	0
3.1.4 Functional comprehensive HCRC with online, web access	Non existent
3.1.5 # of Dziwani HCRC visitors per month	817 (June 2010)
3.1.6 # of IEC/BCC resources accessed from HCRC per month	5,326 (June 2010)
3.1.7 # of health care (Talkline) workers who successfully completed an in-service training program in Other Prevention and others areas, including Malaria and MNCH	0
3.1.8 # of Talkline callers	1,936 (June–December 2010)
<b>Sub IR 3.2 Private sector participation in IEC/BCC programming and capacity building activities increased</b>	
3.2.1 % of national IEC/BCC activities that have support from the private sector with CSH support	0
<b>Sub IR 3.3 IEC/BCC capacity building program for local institutions strengthened</b>	
3.3.1 # of selected local institutions that offer IEC/BCC-related coursework that uses the curricula developed with CSH support	0
3.3.2 IEC/BCC-related pre-service training curricula developed and revised	0
<b>Sub IR 3.4 M&amp;E frameworks for IEC/BCC intervention strengthened</b>	
3.4.1 National Health Strategy M&E Framework (2011–2015) defines the core indicators for IEC/BCC monitoring	0
3.4.2 GRZ IEC/BCC campaign tracking system produces periodic reports	0

### **3.5.1 National Technical Working Group**

The MOH has a national TWG in place that coordinates the development and implementation of IEC/BCC interventions. Although the TWG is in place, there were no specific criteria for appointing the members. In the absence of written criteria for appointment of members, the appointments could be subjective, thereby rendering the TWG less objective in its decision-making.

NMCC has an IEC/BCC TWG comprising representatives from partner organizations that implement malaria prevention and treatment activities. The TWG members provide technical assistance in the development of IEC/BCC materials at the national and district levels. However, the members of the TWG have limited skills in IEC/BCC development and implementation. For instance, a number of the TWG members lack basic knowledge or skills in developing messages, pretesting, and producing IEC materials.

The NAC has developed a Prevention Theme Group with partners from various organizations. The theme group is responsible for coordinating the development of toolkits and guidelines for developing IEC/BCC messages and materials. Other Ad-hoc committees are formed to look into specific areas of the campaign, such as publicity, production of materials, distribution and financing. The committees meet as often as necessary and provide regular progress reports to the NAC.

### **3.5.2 Afya Mzuri Dziwani: Capacity to Manage Information**

CSH, carried out assessments of three HCRCs; Dziwani, MOH, and NAC in order to understand their operations and to explore possibilities for expansion..

Dziwani Knowledge Centre at Afya Mzuri has grown to provide health resources and materials in health topics and issues such as HIV/AIDS, malaria, tuberculosis, maternal and child health, and sexual and reproductive health. but the majority of the materials in the resource center (55%) are on HIV/AIDS, while only 10% are on malaria, and 5% on maternal and newborn child health.

The demand for health information materials stored at Dziwani Knowledge Center is high. In just the month of June 2010, the center received 817 visitors from around the country. Dziwani houses a repository of health materials needed by students, health workers, and organizations. Eighty-six percent of the materials provided at the Center are print materials. The Dziwani knowledge center stocks over 5,000 reports, books, and other health-related materials that can be searched using a Dziwani resource database. However, the database is not linked to a website to allow for external access. One limitation of the center is that it does not have enough materials on MNCH, FP/RH, and malaria. In addition, it lacks a well-developed M&E plan and tools to capture service use and impact of the center.

### **3.5.3 CHAMP HIV Talkline**

The CHAMP HIV Talkline is a phone-in health program that was launched on World AIDS Day in December 2003 and became operational in 2004. The 990 Talkline has expanded its

scope to accommodate callers with other problems other than HIV/AIDS. In partnership with two other institutions, the Talkline audiences can now receive information on male circumcision and human trafficking. The Talkline audiences, both urban and rural, are referred for health care services, primarily to government health institutions, but there is no feedback mechanism with which to follow up these clients.

The Talkline, while providing health information, also ensures confidentiality and 24-hour access for callers. The 990 Talkline remains the only dedicated HIV telecommunications learning program in Zambia and is hosted through two telecommunications companies, ZAMTEL and ZAIN, with a total of 11 functional call lines. There is a plan to include MTN to increase the number of lines. Callers can call and ask for information on any of the focus health topics and can do so in English and local languages, including Bemba, Kaonde, Lozi, Luvale, Nyanja, and Tonga.

### **3.5.4 Participation of Private Sector<sup>1</sup>**

Through the Global Development Alliance model, CHAMP brings on board 16 private sector partners (spanning eight provinces in the country), half of whom have been implementing long-term HIV/AIDS programs. Most of the programs do not implement IEC/BCC campaigns. Under CHAMP, 42% of districts in Zambia are being supported through interventions focusing on prevention, HIV testing, anti-retroviral therapy provision, care and support, and systems strengthening. Out of these, 27% of the districts have Mobile Health Units that directly support 84 rural health centers, including some very hard to reach catchment populations.

### **3.5.5 Capacity of Local Institutions<sup>2</sup>**

In Zambia, the critical shortage of skilled manpower is a major obstacle to providing improved health care service delivery and to achieving the MDGs related to child health, maternal health and in combating priority diseases such as malaria and HIV/AIDS. The shortage is caused mainly by an insufficient production of health workers including health promotion experts. According to the MOH 2011-2015 National Health Strategic Plan, less than 50% of frontline health workers are available in relation to the need for provision of primary health care services. The result is that unqualified staff members run a significant number of health positions.

At the time of this evaluation it was learnt that, in Zambia health promotion courses are offered at post-graduate level and most of these post-graduate courses are conducted outside Zambia at a high cost and often with lower retention rates than are desirable as graduates are tempted to seek employment outside of the country. It was learnt that, only one learning institution was offering health promotion courses at post-graduate level in Zambia. The MSc Public Health (Health Promotion and Environmental Health) course is run at Chainama College in Lusaka, Zambia in collaboration with Leeds Metropolitan University of the United Kingdom. Similarly, there was no specialised research and monitoring and evaluation course for health programs being offered in Zambia. The University of Zambia offers a certificate course in basic M&E introduced in 2008. An assessment of the curricula to determine course contents needs to be done.

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<sup>1</sup> More information regarding the role of the private sector in IEC/BCC campaigns in general needs to be included in this section – see Annex B.

<sup>2</sup> Information regarding the capacity of local institutions in IEC/BCC needs to be included in this section – see Annex B.

### 3.5.6 National M&E Framework and Campaign Tracking System

The national health strategic plans, M&E frameworks, and communication strategies for the GRZ (MOH, NAC, and NMCC) expire at the end of 2010. Currently, the MOH does not have a national M&E plan but uses the HMIS manual to monitor and evaluate its health programs. The HMIS manual does not collect IEC/BCC indicators but concentrates on health service delivery indicators.

The National AIDS Response is supported by a functional national HIV and AIDS M&E system that is based on the “Three Ones” principles. A strong link exists between the national HIV&AIDS M&E system—the goal of which is to track progress made for the national response—and the M&E systems of specific programmatic areas (such as prevention of mother-to-child transmission [PMTCT], clinical care and VCT). The NAC M&E system provides a national overview to enable decision-making and tracking of progress from a national perspective. NAC has developed indicators to capture data to measure the outputs, outcomes, and impact of HIV/AIDS-related activities.

Following the targets set in the National Malaria Strategic Plan 2006–2010 (the Roll Back Malaria partnership in Zambia), NMCC developed an M&E plan to coordinate partner malaria intervention. M&E activities were determined by the NMCC in collaboration with the MOH and the national TWG for IEC/BCC interventions. NMCC reports its output indicators through the MOH structure, that is, IEC/BCC indicators on distribution of materials and training, while outcome indicators are captured through the MIS and the Knowledge Attitude, and Practice study. Impact indicators are captured through the ZDHS.

### 3.6 Intermediate Result 4 (IR 4): Coordination of IEC/BCC Activities Between USAID Projects Increased

IR 4 states that as a result of CSH, the coordination of IEC/BCC activities between USAID projects will increase. The coordination of IEC/BCC activities between USAID projects will be defined as “increased” if the following criteria are fulfilled:

1. A USAID partner framework for IEC/BCC coordination is developed and implemented.

**Table 3.12 CSH Intermediate Result 4 Indicator and Annual Results**

IR 4 Indicator	Baseline 2010
<b>Sub IR 4.1 IEC and BCC planning between USAID programs increased</b>	
4.1.1 USAID partner framework for IEC/BCC coordination developed and implemented	0

### **3.6.1 Coordination of IEC/BCC Activities between USAID Projects**

GRZ works with USG agencies, other CPs, and implementing partners to carry out broad health sector strategies focused on improving the health of Zambians. Other USAID-funded health programs support GRZ integrated service delivery and health system strengthening. IEC/BCC is mainly incorporated in each program as a central tenet to increase knowledge, healthy behaviors, and health-seeking practices that contribute to greater use of services offered by the health system.

Currently there is weak coordination to standardize messages on health behaviors even among USAID agencies due to lack of a common framework.

## 4. CONCLUSIONS

This report presented the results of a baseline evaluation conducted between July and November 2010. It includes the reviews of IEC/BCC campaigns, approaches, messages and materials; assessments for the HCRC, HIV talkline and institutional capacity. It also includes baseline data on project output and intermediate outcome indicators in the CSH's Results Framework and PMEP. The main conclusions per each section of findings, following the PMEP structure, are as follows:

### ***Behavior outcomes and health impact indicators for HIV, malaria, FP/RH and MNCH***

Overall between 2002 and 2007, health impact indicators in the areas of HIV, malaria, FP/RH and MNCH have improved. However, the country needs to sustain this progress in order to meet the MDGs by 2015. The findings for the four health focus areas were as follows:

- **HIV:** HIV prevalence in Zambia, while on the decline in the past years, is still high at 14.3% for adults aged 15 – 49 years old. Condom use among adults who have more than one sexual partner is relatively low among women at 37.4%, but higher among men at about 50%. Engaging in two or more concurrent partnerships is very high among adult men 70%, and lower among adult women at 30%. HIV testing remains very low in Zambia, with only 8.5% of women and 11.7% of men having received an HIV test in the past year.
- **Malaria:** Coverage of malaria prevention and treatment interventions remain below the targets for Zambia, with almost 50% of children under five and about 46% of pregnant women sleeping under ITNs, only 23% of households covered by IRS and only 31.2% of febrile children receiving prompt and appropriate treatment for malaria. Coverage of IPTp is high with almost 70% of pregnant women receiving complete treatment during their pregnancy.
- **Family Planning/Reproductive Health:** Zambia has one of the highest fertility rates in sub-Saharan Africa, with women on average giving birth to 6.2 children. As of 2007, approximately 55% of all births occurred less than three years after the preceding birth. Teenage pregnancy is high in Zambia; over 21% of women aged 15–19 have already given birth to their first child, with the median age at first birth being 19. Contraception prevalence in Zambia is relatively low, with only 31.7% of women aged 15–49 using a modern contraceptive method. As of 2007, three out of four Zambian women either wanted to delay (space) or stop (limit) childbearing. The unmet need for FP is approximately 18% for unmarried women and 27% for married women.
- **Maternal, Neonatal and Child Health:** Maternal mortality remains high in Zambia, at 591 per 100,000 live births. Less than 50% of women deliver in health facilities and about 46.5% of deliveries are attended by a skilled attendant. Although over 90% of Zambian women receive antenatal care (ANC), only 9.8% of women receive a post-natal check-up within the first 23 hours after their delivery. Exclusive breastfeeding for the first six months has significantly improved in Zambia, from 40% in 2002 to 61% in 2007. Conversely, child immunization has declined over the past decade, with coverage only at 68% in 2007 compared to 78% in 1996. Further, of those 68%, only 55% received the complete set of immunizations within the first 12 months of age.

***Project Objective: Capacity of GRZ to Manage Effective IEC/BCC Activities Strengthened***

- **GRZ IEC/BCC management capacity:** Staff members are not trained in IEC/BCC, poor storage facilities and distribution of materials and no formative research is conducted for health communication interventions. In the case of NAC, for example, due to the constrained funding and inadequate human resources, vital activities such as pretesting of materials are not conducted.
- **Use of IEC/BCC Guidelines:** The MOH does have guidelines, but they have not been updated recently, and their implementation and use are constrained by factors such as limited financial and human resources. NAC has developed guidelines, while NMCC has developed written guidelines and procedures for carrying out various malaria-related IEC/BCC tasks. Frequently, implementers do not follow the communication guidelines.
- **Monitoring and Evaluation of Campaigns:** Campaigns are not adequately monitored and evaluated due to low capacity and financial resources. Monitoring tools are also not adequately used.

***IR 1: National Health Communication Campaigns Strengthened.***

An analysis of the national health campaigns (for the period September 2009–August 2010) revealed that:

- None of the seven MNCH, malaria, and nutrition campaigns implemented had been integrated. That is, they all focused only on their own health area.
- Two of the six HIV/AIDS campaigns were comprehensive; that is, only one campaign included messages of more than one HIV topic.
- Though 64% of all the campaigns used two or more channels, none were evidence-based.

***IR 2: GRZ Use of Evidence-Based Health Communications Approaches Increased***

- **GRZ Capacity to Use Evidence from Research:** MOH, NMCC, and NAC health promotion staff has not been trained in formative research or use of evidence to inform the design of health communication campaigns and interventions. The MOH, for example, does not carry out formative research but instead holds consultative meetings with partner and key stakeholders to carry out problem analysis before implementing BCC activities.

***IR 3: Local Capacity to Support Sustained Implementation of IEC/BCC Activities Strengthened<sup>3</sup>***

- **National Technical Working Groups:** The MOH has a national TWG that coordinates the development and implementation of IEC/BCC interventions.

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<sup>3</sup> Additional baseline information related to the involvement of the private sector in national campaigns and the capacity of local institutions in IEC/BCC needs to be collected and included in this report (Annex B).

However, there were no specific criteria for appointing the members, and many have not been trained in IEC/BCC approaches. Similarly in the case of NMCC, a number of the TWG members lack basic knowledge or skills in developing messages, pretesting, and producing IEC materials.

- **Management Capacity of HCRC Afya Mzuri:** Afya Mzuri Dziwani Resource Center has the systems in place to enable immediate expansion in the four focus health areas and services (such as electronic warehousing and distribution). There is great demand for the materials and the center receives numerous visitors. One limitation, however, is that the center does not have enough materials on MNCH, FP/RH, and malaria, and most materials available are print materials. In addition, it does not have an adequate M&E plan or tools to capture service use and impact of the center.
- **The CHAMP HIV Talkline** currently only focuses on HIV. It does not have an M&E framework and, consequently, does not evaluate the impact of its activities. It also does not have a sustainability or marketing plan.
- **National M&E Framework:** The national health strategic plans, M&E frameworks, and communication strategies for the GRZ expired at the end of 2010. Currently, the MOH does not have a national M&E plan but uses the HMIS manual to monitor and evaluate its health programs. The HMIS does not collect IEC/BCC output indicators but concentrates on counting the number of materials produced and distributed and collecting health service delivery indicators.

***IR 4: Coordination of IEC/BCC Activities Between USAID Projects Increased***

- There are currently no harmonized and standardized messages on health behaviors between USAID projects due to lack of a common framework..

In conclusion, the findings of the baseline evaluation not only provide valuable baseline information and indicator levels for the CSH project, but they also help clarify the context in which CSH will be operating and the specific focus areas, in relation to the capacity of the GRZ to implement health communication activities that need strengthening.

## 5. BIBLIOGRAPHY

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## ANNEX A: ADDITIONAL DATA COLLECTION

<b>Report Section/Table to Be Updated</b>	<b>Specific Information to Be Included</b>	<b>Timeframe for Information to Become Available and Report Updated</b>
<b>Table 3.5</b> (page 8)	Baseline levels of specific MNCH indicators from which data will be obtained from HMIS	April 2011
<b>Table 3.6</b> (page 9)	GRZ baseline score on IEC/BCC management capacity index	April 2011
<b>Table 3.6</b> (page 9)	% of national IEC/BCC campaigns that are developed according to minimum GRZ standards/guidelines	April 2011
<b>Table 3.6</b> (page 9)	% of national IEC/BCC campaigns led by GRZ that were developed based on formative research	April 2011
<b>Table 3.6</b> (page 9)	% of national IEC/BCC campaigns that are monitored and evaluated	April 2011
<b>Section 3.5.4</b> (page 19)	Background information regarding the role of the private sector in IEC/BCC campaigns	April 2011
<b>Section 3.5.5</b> (page 19)	Background information regarding the capacity of local institutions in IEC/BCC	April 2011